Long-term care crisis leadership during COVID-19: an interview with Dr. Allan Grill

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Dr. Allan Grill

Dr. Allan Grill is an Associate Professor in the Department of Family and Community Medicine at the University of Toronto, and Chief of Family Medicine at Markham Stouffville Hospital. He enjoys an active community-based clinical practice as the lead physician at the Markham Family Health Team and works part-time in the Division of Long-Term Care at Sunnybrook Health Sciences Centre. In 2016, Dr. Grill received the Certificate of Added Competence (CAC) credential recognizing enhanced skills in care of the elderly from the College of Family Physicians of Canada. Through his various primary care leadership roles, he is currently involved in COVID-19 pandemic planning for the Eastern York Region North Durham Ontario Health Team as well as the Ontario Health Central Region Primary Care Council. Recognizing competency and excellence in physician leadership, Dr. Grill is also a recipient of the Canadian Certified Physician Executive (CCPE) credential from the Canadian Medical Association and the Canadian Society of Physician Leaders.

SC: Tell me a little bit about yourself – who are you and what do you do?

AG: My name is Allan Grill and I am a family physician practicing in Markham, Ontario. I am the Chief of Family Medicine at Markham Stouffville Hospital (MSH), the lead physician for the Markham Family Health Team as well as an Associate Professor in the Department of Family and Community Medicine at the University of Toronto.

SC: In mid-March [of 2020], your hospital was contacted by one of the local long-term care (LTC) facilities in Markham for support with a COVID-19 outbreak. Why did the LTC home reach out to the hospital?

AG: Initially, this was strange because normally nursing homes turn to local public health units when facing an infectious disease outbreak. In speaking with the nursing home medical director and senior executives, we learned they felt they weren't getting enough timely information from public health on how to manage their outbreak. This was likely because public health was overwhelmed, and so the home looked to us next as many patients would be at risk of being transferred to our hospital should their health deteriorate during the outbreak.

SC: Why did the hospital decide to help LTC homes by creating an LTC strategy?

AG: The hospital wanted this for 2 reasons. First, our hospital's strategic plan focuses on "care beyond our walls and supporting patients in the community." This outbreak was an early warning signal for us to try and optimize care at these facilities so that (a) you could try to prevent COVID-19 outbreaks, and (b) if there was an outbreak, you could manage a patient's goals of care in keeping with their wishes and values. For some patients and their substitute decision makers, this would mean providing medical care within the home using existing resources and not transferring them to hospital.

Second, the hospital was concerned that if multiple individuals from LTC facilities got infected with COVID-19 and required treatment in acute care, it would affect their pandemic surge capacity. We were already ramping down services like elective surgeries to prepare for this and were nervous that if you added patients from the nearly 25 congregate settings in our regions, it would greatly affect our ability to respond to the pandemic.

Thus, our hospital realized that we wanted to develop a strategy to optimize care for patients in this setting.

SC: Why were you chosen to help create an LTC strategy for your hospital?

AG: Most of the clinical medical care provided in nursing homes across Canada comes from family physicians. Thus, as Chief of Family Medicine and having years of experience as a family physician working in LTC as part of my clinical practice, my chief of staff assigned me to build an LTC strategy. It's also important to note that I did not create this strategy alone. I work with some great senior executives at my hospital to help put this plan together. This included members of the pandemic command centre, nurse-led outreach team, and infection prevention and control (IPAC) staff. It was a true team effort!

SC: Would you be able to describe what your initial LTC strategy was in your region?

AG: The MSH LTC strategy started off specifically focusing on nursing homes. Initially, I contacted local family medicine department colleagues who happened to be medical directors (a leadership role for family physicians working in LTC), and told them that I wanted to be connected with our community LTC homes to discuss their needs during the pandemic. My colleagues provided lists of all the medical directors for our catchment area of Markham Stouffville Hospital, whom I invited to an initial Zoom meeting. I also contacted all of the nursing directors of care for LTC and retirement homes in our area, local public health, Ontario Health Central regional staff, our community palliative care team, and relevant hospital specialists that could provide support (such as emergency medicine, general internal medicine, and geriatrics). Finally, I invited some colleagues outside of our region that already had experience supporting local LTC homes. For example, the LTC plus program developed at Women's College Hospital provides virtual internal medicine consults to homes with patients who have complex medical problems through a 1-800 phone line. I developed a list of the relevant stakeholders that I thought could help develop an LTC strategy for our community and organized weekly Zoom meetings to engage them.

For the first few meetings in March 2020, we focused on listening to each other, making lists of needs and gaps in care, creating action items and assigning tasks to be completed between meetings. Some examples of resources requested included things like guidance documents around goals of care, emergency department contacts to discuss potential transfers to acute care, virtual internal medicine assessments, referral information for the community palliative care team, and more timely access to blood tests and diagnostic imaging.

SC: Were there any facilitating factors for the success of your strategy? How did these factors change your strategy over time?

AG: The biggest facilitating factor for the LTC strategy happened in mid-April when the Ministry of Health created a directive for hospitals to provide more care for LTC. Hospitals were mandated to help with staffing shortages, infection prevention and control standards, personal protective equipment supplies, access to COVID-19 testing, and hand hygiene education. To implement these, hospitals were advised to develop on-the-ground mobile teams. This meant that our hospital now had official direction that could be leveraged to strengthen our strategy.

Subsequently, we put together a mobile team consisting of nurses and nurse practitioners, along with an oversight taskforce team that met frequently to assess and assist every LTC home. During these meetings, participants stressed the importance of transparency and accountability to improve care for LTC homes in need, and ensure problems were solved in a collaborative manner.

SC: What are the next steps in terms of your LTC strategy?

AG: We are going to transition the LTC strategy over to our Eastern York Region North Durham Ontario Health Team, a group of community organizations that partner to provide services for patients. Some of these partners specialize in caring for older Canadians, such as the Alzheimer's Society. The hospital does not have the resources to continue to support LTC homes using this strategy indefinitely, and the goal is to build capacity within these homes and leverage community organizations to fill any additional care gaps.

SC: COVID-19 highlighted the inequities present in LTC in Ontario. What would you say is one of the biggest barriers to improving LTC in Ontario?

AG: I don't think there has been enough oversight and accountability for LTC homes, retirement homes, and congregate settings in general. There is supposed to be Ministry responsibility of auditing these homes on a regular basis, but in reading the media reports, clearly, they weren't being run up to the standards that are expected.

SC: What are the biggest things that can be done to improve LTC in Ontario?

AG: There have been several reports written on this topic since the pandemic.

First, strong leadership needs a top-down approach. There needs to be accountability if a home fails to meet LTC standards. I don't think the homes meant any harm to their patients, but the oversight needs to be much better. Second, our public health system in Ontario is underfunded, and the pandemic has highlighted that. Public health units do not have enough staffing or resources to fulfill their role. Third, I think the non-physicians (such as personal support workers and nurses) that work in LTC are underpaid, and by extension, underappreciated. They need to be remunerated in a way that doesn't force them to work at different places to make ends meet, as this increases the risk of disease transmission to both residents and staff.

Other ideas include more public funding to improve the infrastructure and design of LTC homes to allow for physical distancing, engaging more family members

and caregiver involvement in policy development (e.g. visitation rules), and incorporating appropriate IPAC standards and education.

SC: If you reflect on your experiences, how would you say your leadership style has changed?

AG: I think I tried to spend more time in a positive attitude space during the pandemic.

Initially, when addressing the problems that needed to be addressed through our LTC strategy, my leadership style was focused on identifying problems and making recommendations to stakeholders on how to remedy it. Through my interactions with our LTC partners, however, I've become more sensitive to the fact that not everybody has the capacity to implement the same solution. Now my approach is more cognizant of others' limitations and engaging them to find solutions to suit their unique needs.

I have also become more comfortable accepting the fact that there are certain things that I cannot change despite my best efforts. I also try to surround myself with individuals who share the same goals and avoid those with negative attitudes who seem convinced LTC can never improve.

Finally, I think that if I am doing something productive and can share my successes (along with lessons learned), I hope that others will take note and be inspired to duplicate and build on them. I also try not to focus on my own personal academic interests or recognition because it allows me to concentrate better on the big picture of creating positive change within my community and health system at large.